Endotracheal intubation skills of medical students

O'Flaherty and Adams in their article (October 1992 *JRSM*, p 740) recommend the use of a stethoscope to verify that the tube is in fact in the trachea.

May I suggest that the quickest, the best, and the most positive method of auscultation is to lean forward, put your ear over the end of the endotracheal tube, administer a sharp push on the patient's sternum. A clear *gust* of air will result if the tube is in the trachea. Anything except a clear gust is unacceptable, and is the signal to remove the tube, ventilate the patient and start again. There is no mistaking that clear gust.

This can all be achieved before you would have time to put your stethoscope in your ears!

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Management of generalized faecal peritonitis

I refer to the article, 'Management of generalized faecal peritonitis: can we do better? (November 1991 *JRSM*, p 664) and the letter on the same subject subsequently published (April 1992 *JRSM*, p 246).

My own experience of 6 years in England in the 1950s, when all patients with faecal peritonitis died, varies very much with the experience over the last 20 years, in which the mortality rate has been very low. Of course antibiotics make a difference; in the 1950s, we virtually only had penicillin, streptomycin and chloramphenicol. However, I believe the main difference has been made by the liberal washing out of the peritoneal cavity as soon as it is entered and the faecal peritonitis encountered. Following whatever procedure is found to be necessary, the peritoneal cavity is further washed out. The final wash did contain Kanamycin until this very useful topical agent was withdrawn from the market. We now use gentamicin. I have not found it necessary to re-open these patients, as residual abscesses have not been a problem. The subphrenic, subhepatic and pelvic spaces would seem to be the most likely to develop abscesses that require drainage; these can be well diagnosed by CT scan and dealt with by those interfering procedural radiologists.

It is interesting to note that in the early history of the surgery of perforated peptic ulcer, washing out the peritoneal cavity was performed. Peritoneal washout was lost to the surgical armamentarium for many decades, possibly because we put too much faith in parenteral antibiotics.

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Double-blind trials and alternative medicine

I was confused by Charlton's publication 'Philosophy of Medicine: alternative or scientific' (August 1992 *JRSM*, p 436). He describes the 'boom' in alternative medicine, and claims that 'scientific' medicine goes from strength to strength.

His explanation for what he calls a 'paradox', though intellectually presented is unable to avoid conventional bias. On the subject of new forms of medical practice he quotes both acupuncture and homeopathy. He has clearly made a study of neither. Yet he has drawn conclusions.

Louis Pasteur had to spend some years on original scientific research, while tolerating the collective censure of the uninformed. Only in the final stage did he disperse his critics by means of double blind trials. Here lies the reason for double blind trials. The mass of scientific endeavour has to take place first. Original science depends on personal observation followed by curiosity, the mark of a scientist, to explain that which cannot be understood without scientific logic and investigation.

'Empirical use of exclusion diets in chronic disorders' (September 1992 *JRSM*, p 556) may serve as a guide to the years of further scientific assessment likely to be required for clarification. Demands for immediate double blind trials are premature and tiresome.

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Delay in seeking treatment for breast cancer

In response to the inquiry by Dr G S Plaut (September 1992 *JRSM*, p 586), the ethics of patient care in this type of situation are quite clear cut. Benificence and paternalism must defer to patient autonomy.

The patient appears to have been given sound and carefully worded advice and she, being an adult of sound mind, chose not to take it; that is her privilege. It was not indicated how advanced her breast cancer appeared to be but most women find the thought of a mastectomy abhorrent and some are not prepared to submit to it. This is why 'lumpectomy' was introduced as a less mutilating and more acceptable operation. Was she possibly a candidate for this lesser procedure and was this possible alternative discussed with her?

The question of treatment of her probable malignancy by an unqualified 'therapist' is a different matter. In Australia, and presumably in the UK, under the Medical Act, certain proscribed diseases, such as cancer, may not be treated by persons who are not medically qualified. Any person believed to be undertaking such irresponsible activities should be reported to the local health authority for appropriate action.

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The portrayal of the physician in non-medical literature

Solomon Posen's article (September 1992 *JRSM*, p 520) beautifully depicts the confrontation of patients and physicians quoting a wealth of contemporary literature sources. It should be emphasized that the image of the physician is a frequent topic in world literature since the dawn of history. Many a literary giant caustically elaborates on the *mores* of physicians. Had it not been for Homer's[1] flattering reference in the Iliad and Ben Sira's[2] in the Old Testament, one might think physicians are a preferential target of poets and writers. The great philosophers of Greece[3], Cato maior, Pliny the Elder, Martial and many others in antiquity[4], Francesco Petrarca with his *'invective contra medicum'* in the high middle ages[5], Jean-Jacques Rousseau of enlightenment fame[6], and